

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
ALBANY DIVISION

MICHAEL NEWCOMB and KATHY	:	NO.
NEWCOMB,	:	1:15-CV-00080-
	:	LJA
Plaintiffs	:	
vs.	:	
	:	
SPRING CREEK COOLER, INC.;	:	
SPRING CREEK PRODUCE, LLC; SF	:	
FARMS, INC.; SF EXPORTS, INC.;	:	
T&L FARMS, INC.; TERRIL SCOTT	:	
PROPERTIES, LLC; TERRIL SCOTT	:	
FARMS, LLC; WALDINE B. SCOTT	:	
FARMS, LLC; EDDIE T. SCOTT	:	
FARMS, LLC; TS EQUIPMENT	:	
LEASING, LLC; L&W FARMS, LP;	:	
TERRIL SCOTT; and JOHN DOE,	:	
Name Unknown, Address Unknown	:	
Defendants	:	

VIDEOTAPE DEPOSITION OF TIMOTHY B. ECKEL, M.D.

Taken in the offices of Timothy Eckel, 1410 Bloom Road, Danville, Pennsylvania, on Wednesday, February 15, 2017, commencing at 9:15 a.m., before Justine Starrick, Registered Professional Reporter, Tim Art, Videographer.

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1 THE VIDEOGRAPHER: The date today is
2 February 15, 2017. The time is 9:15 a.m. This is
3 the videotape deposition of Timothy B. Eckel, M.D.,
4 taken in the matter of Michael Newcomb and Kathy
5 Newcomb versus Spring Creek Cooler, Inc., et al,
6 filed in the United States District Court, Middle
7 District of Georgia, Albany Division. Case number
8 1:15-CV-00080-LJA.

9 This deposition is being held at 1410
10 Bloom Road in Danville, Pennsylvania. My name is
11 Tim Art and I am the videographer. I am with
12 Gallagher Reporting and Video. The court reporter
13 is Justine Starrick. At this time will counsel
14 state their appearance for the record after which
15 the court reporter may swear in the deponent.

16 MR. HELMS: Jeff Helms. I represent
17 the plaintiffs Mr. and Ms. Newcomb in this case.

18 MR. PICKETT: And I'm Mark Pickett and
19 I represent the defendants in this case.

20 * * * *

21 TIMOTHY B. ECKEL, M.D., having been
22 duly sworn, was examined and testified as follows:

23 * * * *

24 DIRECT EXAMINATION

25 * * * *

1 BY MR. HELMS:

2 Q. Doctor, I'm Jeff Helms. We met earlier. I
3 represent the Newcombs. We're going to get started.
4 And I just remind you, you're speaking to the jury
5 in South Georgia. So there's the camera over there,
6 and you're up -- where are we located right now?

7 A. We are in my kitchen of the office at
8 Danville Family Practice, Danville, Pennsylvania,
9 1410 Bloom Road.

10 Q. Doctor, you're a medical doctor?

11 A. Uh-huh.

12 Q. Do you have a specialty as a medical
13 doctor?

14 A. I'm a board certified family physician.

15 Q. Two questions, when you say family
16 physician, what does that mean?

17 A. I am a member of the specialty in medicine
18 that treats the patient as a whole person from
19 cradle to grave.

20 Q. Is what we call in south Georgia maybe a
21 family doctor?

22 A. A family doctor.

23 Q. Treats the whole gambit of problems that a
24 patient can have?

25 A. Yes.

1 Q. From beginning to end of their life if they
2 chose so?

3 A. Correct.

4 Q. Is it usual in your practice that you'll
5 treat somebody for the majority of their life?

6 A. Yeah. Earlier in my career I did
7 obstetrics and have delivered and have second and
8 third generations of patients.

9 Q. How long have you practiced medicine here
10 in Pennsylvania?

11 A. I came here to do my residency in family
12 medicine on July 1 of 1976. I finished that
13 residency program June 30, 1979. I opened my solo
14 family medicine practice here July 1, 1979 and have
15 been in solo medical practice since then.

16 Q. 1979. Help me do the math here. We're in
17 2017, so almost 40 years?

18 A. Uh-huh, almost.

19 Q. All right. And I know we don't want to ask
20 women this, but I'm going to ask you, how old are
21 you, how old are you practicing medicine every day
22 now?

23 A. I am 67 and a half.

24 Q. How many patients do you see on a daily
25 basis on average these days?

1 A. These days it's not as busy as I was, 25,
2 30 on a busy day. I have seen as many as 45 in a
3 day.

4 Q. Where did you get your medical training?

5 A. I went to medical school at Temple
6 University in Philadelphia, and then as I said came
7 to Geisinger and got a residency certification in
8 family medicine at Geisinger Medical Center,
9 Danville, Pennsylvania.

10 Q. I want to go back to another point that you
11 said you're board certified in family medicine. Can
12 you explain to us what it means to be board
13 certified in the field of medicine?

14 A. In Pennsylvania you could get a license
15 after one year of post graduate training. That
16 means one year after medical school you can apply
17 for, pass an exam, and be licensed to practice
18 medicine. If you want to be board certified you
19 have to complete, in family medicine, it's a three
20 year program. And then you take an exam, fulfill
21 other qualifications, and then you could use the
22 title ABFM, American Board of Family Medicine after
23 your name, which means you are a specialist that has
24 been recognized by a recognized specialty board in
25 medicine to call yourself a board certified family

1 doctor.

2 Q. And to get this board certification you
3 have to take a written test?

4 A. You've got to take a written test, which
5 mine is coming up for my recertification this year.

6 Q. And to get it the first time I think -- and
7 that written test, that's a nationwide test?

8 A. That's a nationwide test. It encompasses a
9 full eight hour day. Initially it was every seven
10 years I had to do it. This last time they've
11 extended it with some extra qualifications that we
12 do it in 10 years.

13 Q. And the first time you get it do you have
14 to go through an oral presentation also?

15 A. For family medicine there's not an oral
16 exam.

17 Q. So is it fair to say that a board
18 certification in family medicine is a certification
19 of a higher status in your practice or a -- how
20 would you describe it?

21 A. It's just an extra degree to assure the
22 public that they're seeing a physician who has done
23 the extra work to maintain his qualifications in the
24 specialty and be able to diagnose and treat diseases
25 that would be seen in the family practice.

1 Q. How long did you say you've had this board
2 certification?

3 A. Ever since I started. I got it initially
4 in '79.

5 Q. Okay. Here in Danville have you treated a
6 patient by the name of Michael Newcomb?

7 A. Yes, I have.

8 Q. Treated him about -- how long have you
9 treated the fellow?

10 A. Well, I first saw -- I think I saw his wife
11 before I saw Michael. But my first note on him is
12 June 4, 2002.

13 Q. We're here about an incident that occurred
14 in 2013. So you saw him as a family physician for
15 almost 11 years before the incident here?

16 A. Correct.

17 Q. And on average would you see him at least
18 once a year or more often than once a year for that
19 11 years?

20 A. Well, he had some other medical problems.
21 And I saw him -- Michael is the kind of guy that
22 wouldn't come in unless he had to. So I saw him
23 once or twice a year, didn't see him for two years,
24 2004, and then he had his heart attack somewhere
25 along here and I saw him for that. He had some

1 other health problems. He had some neck pain from
2 his osteoarthritis, and I saw him multiple times
3 closer to this current accident that we're talking
4 about. He had a heart attack in 2010 and I saw him
5 more frequently then.

6 Q. Just talking about that, even when he had
7 the heart attack in 2010, did he go back to work as
8 a truck driver?

9 A. Oh, yeah, he went back.

10 Q. For all the times that you've known
11 Mr. Newcomb before and after this incident has he
12 been a hard worker?

13 MR. PICKETT: Objection, leading.

14 Q. How would you describe his work ethic?

15 A. He has worked all his life, and that's part
16 of the reason why he didn't really keep doctor
17 appointments as much as -- or didn't come in because
18 he was working. He would work 40, 70 hours a week
19 as a long haul trucker.

20 Q. You've seen him since this incident fairly
21 frequently, I think once a month, since he got hurt
22 in 2013?

23 A. Yes.

24 Q. And we're here in 2014 almost four years
25 after the incident. I'm not going to go back

1 through each and every office visit, but I counted
2 up maybe 40 times that you've seen him since this
3 incident, does that sound about right?

4 A. Part of the reason is that I have a policy
5 when I put patients on chronic narcotics I see them
6 every month generally, just to keep tabs on them and
7 to make sure there's no abuse.

8 Q. It's fair to say that you have -- you're
9 going to be able to give the jury a good idea of
10 Mr. Newcomb's condition before this incident and his
11 condition after the incident based on the number of
12 times that you've seen him?

13 MR. PICKETT: Objection, leading.

14 A. Yes.

15 Q. Let me ask you this, Doctor, can you give
16 the jury a good opinion as to Mr. Newcomb's physical
17 overall condition before this incident and after the
18 incident based on the number of times you've seen
19 him as the family treating physician?

20 A. Yes.

21 MR. PICKETT: Objection, leading.

22 A. Yes.

23 Q. Go ahead.

24 A. Yes. I've seen the patient before, I saw
25 how he reacted to some of his other major medical

1 problems, and I saw how he reacted to this accident
2 that we're referring to in this trial.

3 Q. Now, of course we're here mainly about the
4 injuries that he suffered down on the loading dock
5 in south Georgia in June of 2013. We're going to
6 ask you about treatment of those injuries. But I
7 want you to -- and we're going to talk to you about
8 his condition beforehand. So I think you've got a
9 couple of reports that you prepared at different
10 times?

11 A. Yes.

12 Q. Refer to those as you need to, and along
13 the way we'll stop and ask some specific questions
14 about them. But if you could kind of outline to the
15 jury Mr. Newcomb's physical condition before this
16 incident in June of 2013?

17 A. Before June 20, 2013 I had been following
18 the patient. He had several medical problems before
19 this time. He had chronic cervical spondylosis from
20 his years as a truck driver. That just means
21 arthritis in the neck from bouncing around in the
22 truck. A lot of times you get osteoarthritis. And
23 he had been seen several times because of neck pain.

24 Q. Here in Danville, this is kind of coal
25 country. Do you treat truck drivers?

1 A. Oh, yeah, we have a lot of truck drivers.

2 Q. Is that a condition that you see often?

3 MR. PICKETT: Objection, leading.

4 A. Yes.

5 Q. How often would you see that kind of
6 condition in truck drivers?

7 A. Well, it's not obviously limited to truck
8 drivers, but I see cervical spondylolysis a lot. A
9 lot of patients have arthritis in the neck and have
10 chronic neck pain, that's fairly common.

11 Q. What is it about truck driving that may
12 cause that kind of condition?

13 A. Just the constant bouncing.

14 Q. What other issues did Mr. Newcomb have?

15 A. He also had a myocardial infarction, which
16 is a heart attack. He had high blood pressure. He
17 had early signs of diabetes with elevated fasting
18 sugars or glucose. He had high cholesterol. And
19 unfortunately he smoked.

20 Q. He liked to smoke a cigarette?

21 A. He smoked every day.

22 Q. We touched on it before, but despite all
23 that was Mr. Newcomb pretty physically active?

24 MR. PICKETT: Objection, leading.

25 Q. Was Mr. Newcomb physically active given

1 those conditions?

2 MR. PICKETT: Objection, leading.

3 Q. How would you describe Mr. Newcomb's
4 physical condition given all those conditions?

5 A. Well, he was able to, you know, work every
6 day. He was productive. He had some health
7 problems, some of which were related to his
8 lifestyle. But he was functional and he had a
9 family. You know, he was an active, productive
10 member of society.

11 Q. Now, back in June of 2013 of course he got
12 injured and he came to see you. Can you tell the
13 jury about that first time he came to see you based
14 on this injury that this case is about?

15 A. Well, he came into my office -- I think the
16 accident was on June the 20th and he came in the
17 following Monday I believe it was, on June 24, 2013.
18 He had stitches on his head. He looked very bad
19 actually. And he told me he had a -- it was crazy,
20 he had an accident down in Georgia and he drove
21 himself home I remember. He said his company said
22 he couldn't leave his truck there.

23 MR. PICKETT: Objection, hearsay.

24 Q. This is what the patient said?

25 A. This is what he told me. It was something

1 about they wouldn't let him, or he thought they
2 wouldn't let him keep the truck there so he ends up
3 driving it home, which I thought was a little
4 bizarre.

5 MR. PICKETT: Object to the hearsay.

6 A. And anyway he came to my office and he had
7 this big gash on the left side of his head with
8 stitches.

9 Q. I'm going to show you some photographs
10 which I understand you didn't take, but you had a
11 chance to review them this morning, is that right?

12 A. Yes.

13 MR. HELMS: These are going to be
14 Plaintiff Exhibit 1 and Plaintiff Exhibit 2. You
15 had a chance to take a look at these.

16 MR. PICKETT: We're going to object to
17 Plaintiff -- can I see those?

18 MR. HELMS: Yes.

19 MR. PICKETT: 1 and 2 in that we had
20 not previously been provided with these before,
21 about 30 minutes ago.

22 Q. How about showing them to the camera right
23 there. Tell us what they are?

24 A. One is a picture of a head wound, it looks
25 like Michael Newcomb, I recognize his hair and head.

1 But the one that I'm looking at now which is to the
2 right shows a recent head injury with blood around
3 the scalp. I don't remember seeing that. I saw the
4 picture, I don't remember seeing the actual person.

5 MR. PICKETT: On that basis we object
6 to the witness even looking at it. It's not in
7 evidence and he can't authenticate it.

8 Q. You could continue.

9 A. The second photograph which shows a scalp
10 with stitches in it shows active blood clot around
11 the wound. Yeah, I do recognize that as --

12 Q. Do you recognize that from seeing it in
13 your clinical practice?

14 A. Yes, I saw that. That's what he looked
15 like when he first came, similar to that.

16 MR. PICKETT: Just for the record
17 you're referring to the second photograph?

18 THE WITNESS: The one with the
19 stitches.

20 MR. PICKETT: The one on the bottom?

21 THE WITNESS: Yes, it's the one to the
22 right this way. I had it turned upside down.
23 (Indicating.)

24 MR. PICKETT: If we orient the exhibit
25 so the exhibit sticker is on the bottom then it's

1 the photograph on the right that you recognize?

2 THE WITNESS: Yes, that's what I saw.

3 Q. Okay. How about Number 2?

4 A. Exhibit Number 2 shows a stitched
5 laceration of the scalp that is a picture of Michael
6 Newcomb.

7 Q. Is that an accurate representation of how
8 it looked to you when you saw him?

9 A. Yes, that's exactly how it looked.

10 Q. All right. Using this pointer here if you
11 could show that to the jury now and describe the
12 injury that he suffered. Or what you treated him
13 for when he came in?

14 A. This is what it looked like after he
15 healed, he had an upside down horseshoe laceration.
16 You could see that's a fairly large laceration. The
17 stitched had been removed. There's still a scab
18 there from the healing of the laceration. That's
19 the size of the lesion.

20 Q. Now, Number 1 right here you said -- we're
21 going to show this to the jury and we'll get the
22 foundation in later through Mr. Newcomb, so it's
23 okay, don't worry about that. The one to the right
24 is the one that you saw, and the one to the left is
25 not how it appeared when you saw it?

1 A. Correct.

2 Q. Just using the one to the right, describe
3 that?

4 MR. PICKETT: As to both of these
5 continue our previous objections.

6 A. This is what it looked like when he first
7 appeared at the office. It's a dirtier wound with
8 scab that's still present around the laceration.
9 Stitches are still in place in this picture.

10 Q. Thank you. Did he give you an idea about
11 how this incident occurred?

12 A. Well, he told me he had gotten -- driven
13 his truck to this place where he had to unload it.
14 He was --

15 MR. PICKETT: I'm going to object to
16 the hearsay as to what he may have told him how this
17 happened.

18 Q. You could go ahead.

19 A. My understanding is he said he was standing
20 by the end of the truck where it was being unloaded.
21 Somehow he was hit by the fork truck and got knocked
22 into the truck itself and sustained this laceration.

23 Q. Based on Mr. Newcomb's condition, what did
24 you do for him over the course of your treatment for
25 this particular injury here in the short term?

1 Let's talk about the short term.

2 A. Well, initially I managed the wound, made
3 sure it was healing. After the proper amount of
4 time we took the stitches out. But it was not
5 acting like a normal wound. He continued to drain
6 fluid. He had some really unusual symptoms,
7 swelling in his left eye, fullness in his ear, I
8 think he had like pain that was not usual. Most
9 patients like that don't have that much pain. He
10 was having severe headaches. He had to have
11 narcotics to control the pain. It wasn't acting
12 like just a scalp laceration.

13 Q. Did you send him out to a specialist
14 because of continued problems?

15 A. At that point because of ear problems we
16 sent him to Dr. Azeredo who is an otolaryngologist
17 at Geisinger right down the street.

18 Q. Tell us what an otolaryngologist is?

19 A. That's an ENT specialist.

20 Q. What's an ENT specialist?

21 A. One who specializes in the diseases of the
22 ear, nose, and throat. And they're surgeons, they
23 can operate, they also treat ear, nose, and throat
24 problems medically.

25 Q. When you say diseases, does that also

1 encompass -- do you mean injuries to the ear, nose,
2 and throat?

3 A. That would include traumatic injuries as
4 well.

5 Q. So he went to go see Dr. Azeredo, is that
6 right?

7 A. That's correct.

8 Q. That's at Geisinger?

9 A. Geisinger Medical Center.

10 Q. Big medical center here in Danville, is
11 that right?

12 A. Yes.

13 Q. Did Dr. Azeredo, did he send you copies of
14 the records, his clinical records after he saw Dr.
15 -- after he saw Mr. Newcomb?

16 A. Yes, I would get reports from Dr. Azeredo
17 as what his treatment was.

18 Q. Did you keep up with those reports?

19 A. Yes.

20 Q. Was that part of -- part and parcel of your
21 treatment with Mr. Newcomb?

22 A. Yeah, it was very important because, you
23 know, I wasn't sure exactly what was going on. So I
24 needed help from my specialist colleagues to try to
25 sort out what was the problem. So I would depend

1 heavily on what his opinion was.

2 Q. And in the practice of your medicine is
3 that something you do on a regular basis, rely upon
4 the reports of experts they supply to you?

5 MR. PICKETT: Objection, leading.

6 Q. For the treatment of the patients?

7 MR. PICKETT: Object to leading.

8 A. I can answer?

9 Q. Yes.

10 A. Yeah. One of the hallmarks of our
11 specialty is we look at ourselves as family doctors,
12 kind of like the general overseeing the whole
13 battlefield. And a lot of times we need specialists
14 to help us do artillery or whatever, to help fight
15 disease. So, yeah, that's what we do, we send them
16 to different subspecialists to get their opinion.
17 And then we kind of coordinate everything, make sure
18 everything is taken care of and nobody drops the
19 ball because they think somebody else is doing it.
20 So I do that routinely. It takes a lot of my time
21 to read reports from specialists.

22 Q. How did these reports come to you, were
23 they handwritten, from a computer, what kind?

24 A. They get faxed to us. Geisinger has an
25 electronic medical record. I have access to that, I

1 could go in and get the electronic records. But
2 it's easier for our system to have it faxed and
3 scanned into our records.

4 Q. What was the course of treatment for
5 Mr. Newcomb once you realized that he was still
6 having trouble and you referred him to Dr. Azeredo.
7 What course of treatment did he undergo then by the
8 specialist to whom you referred him?

9 A. Well, he had several CTs, MRIs. Finally
10 they discovered there was a crack in the bone in the
11 middle ear, the roof of the middle ear bone was
12 cracked. They had to repair it. He actually had
13 what's called a CSF leak.

14 Q. What is that?

15 A. The fluid that surrounds the brain -- the
16 brain is encased in fluid, and if there's a tear and
17 a crack in the bone it actually could come outside,
18 which is what was happening to Mr. Newcomb. It came
19 into the middle ear and was stopped by the tympanic
20 membrane, the eardrum, and that had to be fixed.

21 Q. What's the danger of having a crack in your
22 skull causing brain fluid to leak down into it?

23 MR. PICKETT: I'm going to object to
24 the question in that it's misleading and it assumes
25 facts not in evidence. And to the extent this goes

1 beyond Dr. Eckel's qualification as a family doctor.
2 He has testified that he had to refer him to
3 Dr. Azeredo for these type of assessments. So I
4 believe this is probably outside his area of
5 expertise.

6 THE WITNESS: Well, that's ridiculous.
7 It's not outside of my area of experience. It
8 doesn't take any specialist -- you know, anybody
9 with a medical degree knows that leaking brain fluid
10 causes problems, one of which is meningitis, which
11 is amazing that this guy got never got meningitis.
12 But be that as it may --

13 Q. Let's just back up.

14 A. That's one of the complications.

15 Q. Are you qualified to answer that question?

16 A. Yes, I could answer that question. Based
17 on my years of experience in treating patients and
18 leaking brain fluid -- I mean, I'm stumbling here
19 because I can't believe you just said that. But
20 anyway.

21 Yeah, leaking brain fluid from a
22 patient's brain is a very dangerous thing. You have
23 a communication from the outside of the body which
24 has skin and lots of germs right into your brain
25 which is a sterile environment. So it's easy for

1 bacteria to get in and infect that, and this guy had
2 it for weeks.

3 Q. Infect the brain?

4 A. Infect the brain. You could infect the
5 lining of the brain, meningitis, you could infect
6 the brain itself. You can have an abscess,
7 encephalitis. You know, it just -- it's
8 traumatizing to me to think how long it took us to
9 figure out what was going on with this guy. I wish
10 we could have done it sooner. It was just difficult
11 because the initial CAT scans were read as normal,
12 they didn't show the fracture, which sometimes can
13 happen with a hairline fracture.

14 But eventually we were able to find
15 out. And it was a difficult situation. You have
16 leaking fluid, you hope it stops, sometimes it does,
17 sometimes the crack will seal itself and the body
18 will heal. You don't want to operate on there if
19 you could help it.

20 Q. How was the --

21 A. Because the operation itself has risk. So
22 we were in that kind of decision, and obviously I'll
23 defer to Dr. Azeredo about that. But eventually the
24 decision was made to do the surgery. And they had
25 to cut out part of his brain, seal the crack, and

1 then hope that the wound would heal and the leak
2 would stop, which eventually it did. It took
3 several weeks after the surgery before it did.

4 Q. What was the test that finally was able to
5 show that he had brain fluid in his inner ear?

6 A. I'll defer to Dr. Azeredo about that. You
7 know, spinal fluid is different than other serous
8 fluid and they can test for sugar content and things
9 to be able to tell exactly what type of fluid it
10 was.

11 MR. HELMS: I'm going to mark Exhibit
12 3, and this is for demonstrative purposes. If you
13 could hand me that illustration.

14 MR. PICKETT: We're going to object to
15 Exhibit 3 on the basis we just got this also about
16 45 minutes ago.

17 MR. HELMS: It's demonstrative
18 purposes. I don't have to present it to you up
19 until the time of trial if I don't have to.

20 MR. PICKETT: Well, since this is
21 being taken for trial, I would argue we should have
22 been provided it prior to the deposition, at least
23 more than 45 minutes into the testimony.

24 MR. HELMS: Okay.

25 Q. Before you show that to the jury, are you

1 familiar with the anatomy of the place where

2 Mr. Newcomb had his injury inside his --

3 A. Yes, somewhat.

4 Q. Is that a fair and accurate representation?

5 A. Yes, this is a standard cutaway frontal
6 section of skull involving the ear.

7 Q. Basically your understanding of reviewing
8 Dr. Azeredo's records and your years of experience
9 and knowledge as a family treating physician, would
10 this illustration help you describe to the jury the
11 anatomy that was injured?

12 A. Yes, it's a very good picture of what
13 happened.

14 Q. You could use this pointer if you need to
15 show that to the jury.

16 MR. PICKETT: Again, I'm going to
17 object. Dr. Eckel just testified he was somewhat
18 familiar with the injury and would defer to
19 Dr. Azeredo. I think Dr. Azeredo would be the
20 better witness to discuss this particular injury.
21 So if we're going to talk about this particular
22 injury for Mr. Newcomb to that extent I would object
23 to have Dr. Eckel testifying about that. If we're
24 talking about general anatomy, I'm sure Dr. Eckel is
25 qualified to talk about that.

1 A. That's all I'm talking about, is the
2 anatomy. So the anatomy here of the middle ear,
3 we've got the inner ear, which is your hearing
4 mechanism, has the cochlea and nerves, the acoustic
5 nerve that helps you hear. And here you have the
6 bones of the middle ear that translate pressure
7 airwaves that pulsate up against the tympanic
8 membrane, the eardrum. And they make the bones of
9 the middle ear, which are the smallest ears of the
10 body -- smallest bones in the body. They make them
11 pulsate and set up a fluid wave here in the circular
12 window and the cochlea.

13 Now, in this space called the middle
14 ear, it's surrounded by bone. And at the top you
15 have the tegmentum of the middle ear. And it sits
16 right at the base of the brain here. And apparently
17 his injury was right here. (Indicating.)

18 MR. PICKETT: Again, I'm going to
19 object to Dr. Eckel testifying about where the
20 injury was in that he does not have direct knowledge
21 of it.

22 THE WITNESS: Well, I do based on the
23 operative report.

24 MR. PICKETT: And, again, that would
25 be hearsay. And I'm going to ask that Dr. Azeredo

1 would be the proper witness for that.

2 Q. You could continue.

3 A. So based on my knowledge of what the report
4 said, and, you know, I rely on these things all the
5 time. So I was not in the operating room, I did not
6 see this, but based on what the consultant's report
7 said, this bone was apparently cracked. There was
8 encephalocele, which meant part of the brain tissue
9 was down through this crack.

10 Neurosurgeon, Dr. Toms, had to get
11 involved with the surgery to cut away the part of
12 the brain, and Dr. Azeredo sealed this part to stop
13 the fluid leak into the middle ear which was bulging
14 the eardrum out.

15 Q. Okay. How did Mr. Newcomb do after the
16 surgery?

17 A. Well, it took some time. It continued to
18 leak as I remember for a few weeks after. But
19 eventually it sealed and he plateaued and is where
20 he is today.

21 Q. All right. And you've treated and seen Mr.
22 Newcomb a number of times since then, is that right?

23 A. Yes, I have.

24 Q. Okay. In preparation for this case, like I
25 said, you've prepared a couple of different reports,

1 and as I said earlier I'm not going to go through
2 all 40 some office notes, but based upon that I'm
3 going to ask you a series of questions, and I'm
4 going to ask for your opinion for you to give to the
5 jury. All these need to be within a reasonable
6 degree of medical probability, that it's more likely
7 than not. Is that fair enough?

8 A. Yes.

9 Q. Can you do that?

10 A. I can.

11 Q. And I'm going to ask you some of your
12 opinions about Mr. Newcomb since then. Can you tell
13 us in your opinion what are, and this would be
14 number 4 on the previous report, what are the
15 injuries that Mr. Newcomb suffered as a result of
16 this blow to the head?

17 A. Well, it was my and is my opinion to a
18 reasonable degree of medical certainty that the
19 following diagnoses were a result of the injury that
20 he sustained on June 20, 2013: He had a fracture of
21 the left tegmen with an encephalocele, and CSF leak
22 as I just referred to.

23 Q. Tegmen, is that the bone --

24 A. Tegmen is the top roof bone of the middle
25 ear.

1 Q. Inside the skull?

2 A. Inside the skull. And that's the part that
3 cracked and the brain tissue herniated through it.

4 Q. Is that the encephalocele?

5 A. Yes, encephalo means brain and cele is the
6 crack through.

7 MR. PICKETT: For the record we will,
8 excuse me, object on the same basis we've previously
9 stated.

10 A. And when that bone is cracked and meninges
11 is torn it allows that fluid to leak through and
12 that's what was causing his symptoms. So that was
13 the one injury that he had. That was repaired by
14 the craniotomy. And as I said before according to
15 operative report part of his brain tissue had to be
16 cut away.

17 Q. Craniotomy, what is that?

18 A. Craniotomy is when you cut through the
19 skull bone to get into the brain cavity to treat
20 whatever you're treating.

21 Q. Does Mr. Newcomb, does he have like a metal
22 plate in his head right now, or is it --

23 A. He's got a scar on the scalp. I'm not
24 aware of any metal plate.

25 Q. So they were able to replace whatever they

1 had to cut away?

2 A. Usually you put the bone back in place.

3 Q. Okay. I got you.

4 A. Secondly he had a -- when you have this
5 kind of injury you could also damage the brain
6 tissue itself, it's call a traumatic brain injury.
7 We hear about it on the news all the time with
8 football players and other people that get
9 concussions. And as a result he had -- he exhibited
10 symptoms of traumatic brain injury. He had a
11 definite change in his personality, his emotions,
12 his thinking.

13 Q. Have you treated people over the course of
14 your 40 years of practice --

15 A. Oh, yeah.

16 Q. With that brain --

17 A. I've seen it a lot. I've seen it in
18 athletes, I've seen it in people in car accidents.
19 It's a sad thing. It's a lot more serious than what
20 we used to think. That's why we do so much now with
21 kids and concussions. We have whole new protocols
22 now about how they can play sports after a
23 concussion.

24 Q. Based on your experience of Mr. Newcomb
25 before this incident and after the incident and

1 based on what he's told you it's affected this brain
2 injury, how it's affected him, what are some of the
3 symptoms that he's exhibiting now, problems he's
4 having now from this brain injury?

5 A. Well, he has problems concentrating. He
6 can't think as well as he used to. He has lost a
7 lot of emotional control. He says things that are
8 inappropriate sometimes. He yells at people.

9 When you have an injury like this it's
10 difficult to live with. It's hard to -- it's hard
11 to see in somebody that you love -- soldiers get it
12 from trauma, battlefield injuries. I've treated a
13 number of patients over the years with this, and
14 unfortunately it tears families apart because most
15 families can't handle it and leave.

16 Q. Has it been tough on the Newcombs?

17 A. It has.

18 Q. What have you observed as their family
19 physician?

20 A. It has been -- his wife has told me it's
21 been difficult at times.

22 MR. PICKETT: Object to the hearsay.

23 Q. You could go ahead. Is Mrs. Newcomb your
24 patient?

25 A. Mrs. Newcomb is my patient. And she has

1 told me it's difficult for her at home and because
2 he sits on the couch and yells at everybody.

3 Q. Is what she tells you important of your
4 overall care and treatment of Mr. Newcomb?

5 A. Yes. Yeah, I treat the family and I get
6 input from several of the family members. So anyway
7 he's had those problems. He's had other injuries as
8 well. He has some decreased hearing in the left
9 ear, some vision difficulty, blurred vision. He has
10 chronic post-traumatic migraine headache that he's
11 getting botulinum toxin for, Botox injections, have
12 helped somewhat. He needs the narcotics to control
13 his pain. He's had some balance issues with damage
14 to the left middle ear and the brain. He's -- the
15 arthritis that was in his neck is probably worsened
16 because of the injury.

17 Q. When you say worsened --

18 A. More pain.

19 Q. He had problems beforehand?

20 A. He had arthritis before.

21 Q. But as has this type of injury, has it
22 exacerbated and aggravated, made worse the
23 pre-existing condition?

24 A. Yes.

25 MR. PICKETT: Objection to leading.

1 Q. Was that a condition that existed prior to
2 this incident?

3 A. Yeah. He had a, as I testified earlier, he
4 had arthritis in his neck and I've seen him before,
5 it would flare up on occasion. But it's my opinion
6 to a reasonable degree of medical certainty that
7 that arthritis was made worse by this injury because
8 he's got more pain now in his neck, much more severe
9 actually than it was before.

10 Q. Based on years of treating people in car
11 wrecks and different types of trauma, does a blow to
12 the head, does that -- can that aggravate and make
13 worse arthritis in the neck?

14 MR. PICKETT: Objection to leading.

15 A. Yes, it can.

16 Q. And how would that do it?

17 A. Just the jarring of the bones just kind of
18 stretches ligaments. It disrupts some of the bony
19 juxtaposition or adjustments, alignments of the
20 bones and it causes inflammation, which can
21 precipitate or aggravate the ongoing arthritis
22 that's already in the neck. It just makes things
23 worse.

24 Q. Doctor, do you have an opinion within a
25 reasonable degree of medical certainty of whether or

1 not these conditions you've talked about with Mr.
2 Newcomb are permanent?

3 A. It's my opinion, again, to a reasonable
4 degree of medical certainty, that these problems
5 will persist for Mr. Newcomb for the rest of his
6 life.

7 Q. You talk about narcotics and how Mr.
8 Newcomb has to come in every 30 days now, is that
9 right?

10 A. That's correct.

11 Q. And why do you handle it like that?

12 A. Well, narcotics are dangerous. They're
13 controlled substances. They relieve pain, but they
14 also have a lot of side effects, one of which is
15 addiction. We've discussed this with Mr. Newcomb.
16 Unfortunately his pain is to the point that this is
17 the only thing that helps him. So what I do with my
18 patients who are on chronic narcotics is I generally
19 have a written drug contract, and patients know they
20 can only get these controlled substances from me.

21 Q. Let me -- when you say you have a written
22 drug contract, explain that to the jury, what do you
23 mean --

24 A. Either written or verbal. I talk to the
25 patient and I tell them, you know, you're going to

1 get narcotics from me, you can only get them from
2 me, you cannot get them from any other doctor. That
3 prevents doctor shopping and taking other controlled
4 substances that I don't know about. Fortunately in
5 Pennsylvania we recently just got a prescription
6 drug monitoring program established. And now we
7 can, and by law, we have to when we prescribe them,
8 every time we prescribe them, we have to go into the
9 database and check and make sure they have not
10 received them from any other physician. So it takes
11 extra work, plus, it's my opinion that it's better
12 medical care to keep close control over these
13 patients because the risk of addiction is real, and
14 a lot of times there is an event called an
15 unintended overdose where you take these drugs at
16 the prescribed doses the correct way and it still
17 can suppress your respirations and cause you to die,
18 stop breathing. So they're dangerous, and that's my
19 policy that I see these patients every month.

20 Q. I guess during the course of your practice
21 do you see some patients that might try to abuse
22 these drugs?

23 A. I have, yes.

24 Q. Based on your experience of Mr. Newcomb
25 since 2002 up through today does he give you any

1 indication or symptoms that he is abusing these
2 narcotics in any kind of way?

3 A. No, I don't think he's abusing them.

4 Q. Are they absolutely necessary for him to
5 function during the course of the day?

6 A. They are absolutely necessary for him to
7 function. I wish they weren't, but they are.

8 Q. All right. Moving on. There have been
9 some questions about whether or not Mr. Newcomb
10 could return to work. And I think even at one point
11 it was suggested that Mr. Newcomb could do the work
12 of a cleaner, a team member at Arby's, a cashier,
13 sandwich maker, crew member, front desk clerk,
14 things such as that?

15 A. That's correct.

16 Q. Do you remember that?

17 A. The insurance company wanted him to get
18 back to work.

19 MR. HELMS: Okay. We'll both just say
20 we can't talk about the insurance and we're going to
21 edit out all this part, so let's start over. Is
22 that fair enough?

23 MR. PICKETT: Yeah, we don't want that
24 word.

25 THE WITNESS: That's who told him.

1 MR. HELMS: We know that.

2 THE WITNESS: Put that in the jury.

3 I'm ticked off about this, jury, this guy should
4 never go back to work.

5 MR. HELMS: We're back on the legal
6 record now.

7 BY MR. HELMS:

8 Q. During the course of your treatment of Mr.
9 Newcomb at some point there's a number of jobs
10 suggested that he could do?

11 A. Yes. Someone suggested that he could go
12 back to work as a fast food operator, whatever. The
13 problem is with his injury, with traumatic brain
14 injury or any brain syndrome you lose a lot of your
15 frontal lobe function just from the trauma of the
16 brain. You lose some soft subtle social graces that
17 we all have and know and need to get along with
18 people. He's lost a lot of that.

19 It's my opinion to a reasonable degree
20 of medical certainty that he will -- he is totally
21 and permanently disabled. No person is going to
22 hire him. If they hire him he's not going to be
23 able to stay in a job because he's going to lose his
24 temper, he's not going to get along with his
25 coworkers or customers and he'll be fired. It's

1 just not going to work.

2 Q. Mr. Newcomb at the time of this incident
3 was a long haul truck driver, can he do that?

4 A. Absolutely not.

5 Q. What's the dangers of him driving a big
6 truck?

7 A. Your truck you're driving you need instant
8 reflexes. I would not -- he should not be driving
9 in my opinion.

10 Q. Should not be driving at all, period?

11 A. Should not be driving, and I've told him
12 that.

13 Q. Does he sometimes cheat and drive to your
14 knowledge?

15 A. I'm not going to answer that question.

16 Q. What would be the limitations, and this is
17 number 6 in your report, that you would think would
18 be fitting for Mr. Newcomb right now?

19 A. Well, I stated that his limitations should
20 include no driving, he should avoid all stressful
21 environments, because stress makes his condition
22 worse, so that would include personal stress, job
23 related stress, work related performance goals,
24 production goals, piece work. So anything that adds
25 stress to him, he's not going to do well at. He's

1 going to lose his temper, he's going to get more
2 nervous, and he's not going to be able to function.
3 He can't function in a capacity where multitasking
4 is required. He's not going to be able to relate
5 well to coworkers or to the general public. And he
6 probably should have a weight restriction of around
7 20, 25 pounds at most.

8 Q. Doctor, of course we always want the best
9 outcome of any kind of medical treatment, we know
10 sometimes that doesn't happen. But in your opinion
11 could you tell the jury what would be the best
12 scenario for Mr. Newcomb going forward from this
13 point based on your examination and treatment of him
14 over the years?

15 A. My opinion to a reasonable degree of
16 medical certainty is that he's plateaued, he's not
17 going to get better. These patients do not improve.
18 I've just never seen it in my 38 years of medicine.
19 Unfortunately he's stuck where he is and he's
20 probably going to need narcotics for the rest of his
21 life. His life has been changed forever. You know,
22 he was fine, he was functioning before the accident.
23 Since the accident he's reduced to -- well, I'll
24 give you an example. He was trying to work around
25 the house, he goes and he cuts his finger almost off

1 because he couldn't react fast enough, didn't have
2 the coordination, didn't have the multitasking to be
3 able to handle a power saw.

4 Q. And you treated him for that, is that
5 right?

6 A. Well, I saw him afterward. He had to go to
7 the ER and went to the operating room to get some
8 ligaments fixed with that injury. He just can't
9 work.

10 Q. How about medications into the future, in
11 your opinion what's he going to need?

12 A. Well, he's going to need probably the
13 Botox. He's going to need -- because that does help
14 him. He's going to need narcotics.

15 Q. In your opinion, medically, your research,
16 your experience with your patients, does the Botox
17 tend to help people who have chronic headaches and
18 migraines?

19 A. It can, yes, not everybody.

20 Q. Has it provided him some relief?

21 A. It has given him some relief, yes.

22 Q. In your position as a family physician, if
23 a medication or a treatment works, you go with it?

24 MR. PICKETT: Objection, leading.

25 A. Well, again, I defer to my subspecialist

1 colleagues. I refer him to neurology for these
2 headaches. And the particular neurologist that he's
3 seeing has expertise in Botox. And she has been
4 giving him the shots and they work and I say sure,
5 keep it up.

6 Q. She's a neurologist from Geisinger, is that
7 correct?

8 A. Yes.

9 Q. Dr. Kelley?

10 A. Dr. Kelley.

11 Q. And you've reviewed her records also?

12 A. Yes.

13 Q. In your opinion is Botox a legitimate form
14 of therapy for Mr. -- medically necessary therapy
15 for Mr. Newcomb?

16 A. Yes. It's an FDA approved treatment for
17 this problem and it works for him. So I certainly
18 agree with continuing it.

19 Q. Has Mr. Newcomb as a patient, has he
20 complied with your medical advice, has he done what
21 you've asked him to do to try to get better?

22 A. Yeah, he has generally done everything that
23 I've asked him to do.

24 Q. Are there some things he hadn't done,
25 smoking I guess?

1 A. Smoking is one. Yeah, he -- I'm just
2 thinking here, he wants to get back to work, he
3 doesn't want to be sitting at home on a couch. And
4 I'm trying to -- yeah, there's nothing that I could
5 think of that he -- that I have suggested that he
6 was not willing to do. He's gone to all the
7 specialists that I referred him to. So, you know --

8 Q. That was going to be one of my last
9 questions, has he exhibited a genuine desire to get
10 better?

11 MR. PICKETT: Objection leading.

12 A. Yeah, absolutely. Well, I can just --

13 Q. Let me back up and ask you this. You have
14 patients that sometimes appear to you not to want to
15 get back to work?

16 A. Yeah, I have had a few what we call
17 malingerers or just feel better being disabled.

18 Q. Yeah.

19 A. Not too many. In my experience most
20 patients really do want to work. This is absolutely
21 one who wants to work. He has been a hard worker
22 all his life and as a man that's his thing, he likes
23 working. As I said, he was trying to build onto his
24 house doing a project around the house and his son
25 was helping him and he injured himself. So he has a

1 hard time just sitting at home doing nothing.

2 Q. Would you continue to be Mr. Newcomb's
3 doctor?

4 A. Absolutely.

5 MR. HELMS: Doctor, thank you very
6 much. Mr. Pickett is going to have some questions
7 for you.

8 MR. PICKETT: Do we want to take a
9 break before I do these, are or are we good?

10 MR. HELMS: It's up to the doctor.

11 THE WITNESS: I'm fine.

12 MR. PICKETT: Court reporter?

13 THE WITNESS: I'll take a drink.

14 (Discussion held off the record.)

15 MR. PICKETT: Back on.

16 * * * *

17 CROSS EXAMINATION

18 * * * *

19 BY MR. PICKETT:

20 Q. Dr. Eckel, you saw the wound that Mr. Eckel
21 had, correct?

22 A. Mr. Newcomb, yes.

23 Q. I'm sorry, Mr. Newcomb had. And that
24 injury was to the left side of his head?

25 A. That's correct.

1 Q. And do you want to look at your notes to be
2 sure?

3 A. Yes.

4 Q. Well, maybe not from the photographs, but
5 do you have indications in your records of it being
6 on the left or right side?

7 A. Do you want me to look?

8 Q. Yes, sir.

9 A. Yes, it was the left side.

10 Q. So you conferred with your notes and we're
11 certain absolutely positively this was on the left
12 side of his head?

13 A. Yeah.

14 Q. So you're sure about that. The -- if you
15 look at your records you treated him since back as
16 early as I believe you said 2002, is that correct?

17 A. Yes.

18 Q. Do you remember him having an occasion or
19 complaints of dizziness back as early as 2002?

20 A. Do I remember it, no.

21 Q. Can you refer to your records and maybe
22 look at the entry from his visit on June 4 of 2002,
23 see if that can refresh your recollection?

24 A. Yes.

25 Q. He did have dizziness in June of 2002?

1 A. He apparently said he became suddenly dizzy
2 at work.

3 Q. Okay.

4 A. On June 4, 2002.

5 Q. Then a couple of years later in treating
6 him he had a head injury in 2004, you treated him,
7 if you look at the record, on November 1 of 2004.

8 A. Yes.

9 Q. And the head injury that he had in 2004,
10 late 2004, that injury was also to the left side of
11 his head, correct?

12 A. He had a laceration of his left forehead
13 with seven or eight subcuticular sutures at that
14 time.

15 Q. And there was actually a problem with one
16 of these sutures that migrated and had to be removed
17 later on. It didn't stay where it was supposed to
18 be, did it? I believe if you would look at the
19 record on 11/04 of 2004.

20 A. That's correct.

21 Q. And then the stitch was actually removed
22 about a week later, the suture was removed about a
23 week later on 11/11/04.

24 A. That is correct.

25 Q. And when we say a suture migrates, that

1 means where it's originally placed it doesn't stay
2 there, but it moves through the body?

3 A. I'm not sure if it migrated. But
4 apparently the one suture was tied into the
5 subcuticular sutures, the knot got tied in there.
6 The one is dissolvable, the other one has to be
7 removed. It couldn't be removed so they both had to
8 be cut out.

9 Q. Did you remove those stitches?

10 A. Apparently, yes.

11 Q. But you weren't able to remove one of the
12 stitches --

13 A. Well, the one that was to be removed
14 couldn't be removed because it got tied into the
15 subcuticular suture that dissolved. So eventually
16 we did remove it.

17 Q. The stitches basically got wrapped up with
18 each other?

19 A. Yes.

20 Q. In layman's words?

21 A. Yes.

22 Q. So you had to remove it later than you
23 hoped to?

24 A. Yes.

25 Q. From the accident that he had in 2004 he

1 had an injury to his eye as well?

2 A. Apparently there was some soft tissue
3 injury around the right eye.

4 Q. Okay. And it was your opinion at that time
5 that the -- this injury was probably caused by his
6 head impacting the steering wheel of his truck?

7 A. Did I say that?

8 Q. If you look at your record on November 11,
9 2004.

10 A. That's what it states in the medical
11 record, yes.

12 Q. And as a result of that injury he had
13 headaches, correct?

14 A. Yes, I refer to headaches and I had him
15 come back so see if they were gone.

16 Q. You saw him subsequent to that on January
17 the 10th of 2005. Can you look at that office note?

18 A. Yes.

19 Q. And he still had -- at that time still had
20 some numbness in his forehead?

21 A. The note reads, he comes in for re-check.
22 He smokes about a pack of cigarettes a day. Again,
23 he was told about not smoking. He keeps trying to
24 stop. He had some numbness of his forehead two
25 inches above or behind his hairline. Used to be

1 about four to five inches behind the hairline. So
2 it was improving, still has constant headache.

3 Q. And the side of the head we're talking
4 about there is again on the left side, correct?

5 A. It doesn't say which side it is.

6 Q. Okay. If we look to the initial injury
7 back in November it was on the left side?

8 A. Left forehead.

9 Q. So it's the same area where --

10 A. I assume, yes.

11 Q. As far as the headaches, there was some
12 discussion in his January 2005 visit that they may
13 be being caused by the painkillers he was taking, is
14 that correct?

15 A. At that time I stated in the record that he
16 has to see if he could stay off the pain medicine to
17 see if it goes away, the headaches.

18 Q. He told you he still had a constant
19 headache and he thought it might be due the pain
20 medication?

21 A. Sometimes you could get a rebound
22 phenomenon with pain medication which actually
23 causes headaches.

24 Q. Before we talk about the headaches and the
25 painkillers, may I refer you to one more note

1 further down the line, July 6 of 2010. Have you got
2 that one?

3 A. Yes.

4 Q. And, again, this is before the accident
5 that we're here talking about today by about three
6 years. In July of 2010 he told you he was having a
7 lot of problems at home, didn't he?

8 A. Correct.

9 Q. And that his in-laws had moved in and he
10 was feeling left out?

11 A. That's correct.

12 Q. As far as painkillers go he started taking
13 Vicodin, this is June 22, 2004, if you want to refer
14 to that note.

15 A. Yes.

16 Q. Back in June of 2004 he had fallen out of
17 his truck and injured his left knee, is that
18 correct?

19 A. Yes, he had an old knee injury and he fell
20 out of his truck. I saw him on the 22nd. He said
21 he fell out about 11 days previous to that. He was
22 given a prescription for Vicodin, which is
23 Hydrocodone, 5 milligrams, with 500 milligrams of
24 Tylenol.

25 Q. Earlier we were talking about narcotics,

1 Vicodin is a narcotic, is it not?

2 A. Vicodin is a controlled narcotic, yes.

3 Q. He took that -- you first prescribed it in
4 June of 2004. He continued to take it, it was
5 renewed in -- on November 2, 2004, is that correct?

6 A. Yes.

7 Q. And continued to take it up until January
8 10 of 2005 when there was concern it was causing him
9 headaches?

10 A. Yes.

11 Q. Subsequently in 2009 he started having pain
12 with his neck, cervical pain you talked about
13 earlier?

14 A. He would have that off and on, yes.

15 Q. Well, June 1 of 2009 he began taking
16 Percocet for that pain, correct?

17 A. That's correct.

18 Q. And Percocet is also a narcotic?

19 A. Percocet is Oxycodone and it is a
20 controlled narcotic.

21 Q. Okay. He was renewed for his Percocet in
22 -- you first prescribed it in June, renewed in
23 August and October of '09.

24 A. He had several renewals for Percocet, yes.

25 Q. But he was actually renewed two months

1 later in August --

2 A. He had another prescription June 15.

3 Q. So we had the first one in June, another
4 one June 15, one on August the 6th, and another one
5 on October 16, all in October 2009?

6 A. Correct, 60 tablets, no refills.

7 Q. He missed a couple of appointments with you
8 in December of '09, the 17th and the 21st?

9 A. Well, he canceled and rescheduled, yes.

10 Q. And ended up coming back, his next
11 appointment was January of 2010, and he got another
12 refill for Percocet?

13 A. January 4, 2010 he got 60 tablets, no
14 refills.

15 Q. Got another refill in February, the very
16 next month?

17 A. Correct.

18 Q. For Percocet he got another refill in April
19 for Percocet?

20 A. Correct.

21 Q. He got another refill in May for Percocet?

22 A. Correct.

23 Q. He got Percocet renewals in September and
24 December of 2010 as well?

25 A. September -- August, September, November,

1 December 2010.

2 Q. September, October, November, and December?

3 A. September, November, December.

4 Q. Of 2010?

5 A. Correct.

6 Q. Okay. So that's one, two, three, four,
7 five -- seven of the 12 months in 2010 he got
8 refills for Percocet?

9 A. I count nine.

10 Q. Nine. Nine out of the 12 months he got
11 refills for Percocet. And if we look at 2011 he is
12 still taking Percocet and he was prescribed Percocet
13 in January, March, April, and October. Are there
14 any other months?

15 A. January, February, April, October.

16 Q. Of 20 --

17 A. I'm referring -- can I show the jury this?

18 Q. Sure.

19 A. I'm referring to his paper chart. This is
20 before our electronic records. I have a medication
21 list which I try to keep up, and every time he gets
22 a prescription I write it in here.

23 Q. And he has gotten prescriptions for
24 Percocet in the year 2011, how many months do you
25 show?

1 A. January 3, February 10, April 29, October
2 13.

3 Q. So four months that year?

4 A. Correct.

5 Q. And then in 2012 he got, my records that I
6 have copies of show May and August?

7 A. This has one entry, January 16, 2012, this
8 was around our conversion to the EMR, so the others
9 might be in the electronic record.

10 Q. If you look at your office records on May
11 and August of 2012, those would be May 18?

12 A. Okay.

13 Q. Of 2012.

14 A. So for the jury now I'm looking at his
15 electronic medical record, and we have a thing
16 called an RX Manager that should give me a history
17 -- should show me all the dates for all the refills.
18 The note says, just refill medications on May 18,
19 2012.

20 Q. Okay. And in May of 2012 he got a three
21 month supply of Percocet?

22 A. That may be, yes.

23 Q. Three months later on August 6 of 2012 he
24 got another renewal or refill for Percocet?

25 A. August the 6th.

1 Q. Yes.

2 A. He got prescription ready tablets, no
3 refill.

4 Q. At that time he was being prescribed about
5 40 tablets per month, correct?

6 A. Well, somewhere around 30. The script on
7 August 6 for 80 tablets lasted until October 22. So
8 that was a little bit over 2 months.

9 Q. A little bit over two months for 80
10 tablets?

11 A. Yes.

12 Q. So that's a little more than over a tablet
13 a day?

14 A. Yes, which is not that high of a dose.

15 (Telephone call interrupted the
16 deposition.)

17 THE WITNESS: My racquetball partner.

18 Q. So if you saw him on, if you look at your
19 note, from March the 15th of 2013.

20 A. March 15?

21 Q. March 15, 2013.

22 A. Give me that date again please.

23 Q. March 15 of 2013.

24 A. Oh, I'm sorry.

25 Q. Okay. You made a note in your record at

1 that time that what you were treating him for was,
2 quote, long term drug monitoring?

3 A. No, that term, when I use that term that's
4 a code word for me that I am monitoring his body's
5 reaction to drug use, not just narcotics, but any
6 kind of medicine.

7 Q. Okay.

8 A. So like a lot of medicines affect the liver
9 and kidneys and things like that, so I have to check
10 kidney function, liver function and that's what that
11 means.

12 Q. But in fact started taking Vicodin in 2004,
13 started Percocet in 2009, was taking Percocet daily
14 if not more than once daily throughout 2009, '10,
15 '11, '12. So the long term drug that you were
16 monitoring for him was a narcotic, correct?

17 A. No, actually. I mean, that dose -- you
18 know, I don't like narcotics. I don't like patients
19 on it, there's just so many problems with them. But
20 that's a fairly low dose. Actually what I was
21 monitoring was his Zocor, Simvastatin, for his heart
22 disease. That can affect the liver and you have to
23 get liver enzymes and other blood tests. That's
24 what that was for.

25 Q. Narcotics can affect the liver, can't they?

1 A. Yeah, but not at that dose in my
2 experience.

3 Q. Narcotics can cause headaches, can't they?

4 A. They can. You could get rebound headaches
5 from narcotics, any kind of pain pill.

6 Q. Narcotics can cause dizziness, can they
7 not?

8 A. They can.

9 Q. They can cause mood changes?

10 A. I mean, I always tell patients you die from
11 any drug, any drug can cause any symptom.

12 Q. But a narcotic specifically can cause a
13 mood change, can it not?

14 A. It can.

15 Q. Okay.

16 A. That's -- you know, it can.

17 Q. After this accident instead of the Percocet
18 he started taking OxyContin and Oxycodone, correct?

19 A. Correct.

20 Q. Initially. And then more recently he is
21 now taking morphine?

22 A. Correct.

23 Q. His morphine prescription amounts to four
24 doses a day?

25 A. Currently -- let me review my record. He's

1 on an extended release morphine sulfate 60
2 milligrams. He takes one of those every 12 hours.
3 And he's on an immediate release preparation that he
4 can take for breakthrough pain. And he's on 15
5 milligram tablets of the immediate release morphine
6 sulphate, and he gets 60 of those a month. So he's
7 taking on average two of those a day.

8 Q. Two of the immediate release and two of the
9 extended release?

10 A. Correct.

11 Q. So a total of four morphine tablets a day?

12 A. Correct.

13 Q. That's a pretty high dosage of morphine?

14 A. That's a fairly high dose, it's kind of a
15 middle dose.

16 Q. When he was taking Oxycodone, and if you
17 need to refer to a record it's August 19, 2013, he
18 was taking Oxycodone at least four to five times a
19 day and sometimes seven times a day?

20 A. That was on just flare ups of his
21 osteoarthritis of his neck pain, not usually.

22 Q. But I'm talking when he was taking
23 Oxycodone and OxyContin in August of 2013, was that
24 for his neck pain?

25 A. Oh, August of -- I thought you were

1 referring to before. After the accident?

2 Q. Yes, sir.

3 A. It might be, do you want me to check the
4 records?

5 Q. Yes, if you want to, I would like for you
6 to be accurate, August the 19th of 2013?

7 A. At that time the record states that his
8 medication he was taking four to five times a day,
9 sometimes seven times a day, Oxycodone 10
10 milligrams. Wasn't abusing it. He said his
11 scale -- his pain on a scale of 0 to 10 he said was
12 a 10.

13 Q. That's a good bit of Oxycodone for him to
14 be taking, is it not?

15 A. That's -- yeah, that's a moderate to high
16 dose. With that much medication that's one reason
17 why we switch a patient to a longer acting drug.

18 Q. And Oxycodone and OxyContin, those are also
19 narcotics, correct?

20 A. Correct.

21 Q. And morphine is of course a narcotic?

22 A. Correct.

23 Q. All those narcotics, those are dangerous
24 medications?

25 A. They are.

1 Q. That's why you have this contract with him
2 and that's why you monitor their drug use?

3 A. Yes.

4 Q. One of the conditions is he is not supposed
5 to drive?

6 A. That's my recommendation.

7 Q. That was I believe in the list of things,
8 that was number one on your list as far as your
9 recommendation, wasn't it?

10 A. That's a recommendation. And certainly on
11 these medications you've got to be careful. The way
12 we approach that medically because we're in such a
13 litigious environment, is I always tell patients, if
14 you're on a narcotic, do not drive. Some patients
15 can drive safely on narcotics, it doesn't affect
16 them to the point where it slows their reaction
17 time. But I always tell patients, if you get in any
18 kind of accident and the opposing attorney finds out
19 that you have narcotics in your system, they'll fry
20 you. So I always advise patients, never drive on
21 these medications.

22 Q. Would it surprise you to know shortly
23 before November 18, 2015 he drove all the way from
24 here in Pennsylvania to south Georgia?

25 A. What year was this?

1 Q. In 2015, November 18, 2015?

2 A. Would it surprise me?

3 Q. Yes.

4 A. No, it would not surprise me.

5 Q. And why not?

6 A. Because I, how do I say this --

7 MR. HELMS: Sure, you could give your
8 opinion.

9 A. Because that's Michael.

10 Q. But he's not supposed to be driving?

11 A. He's not supposed to be doing that.

12 Q. And if he did that and his wife was with
13 him and she was available to drive but he just chose
14 to drive, that's not something he's supposed to be
15 doing is he?

16 A. Well, he's not. This guy is a whatever, 30
17 year truck driver, and I'm sure he's safer than most
18 people on the road. But I would never -- you know,
19 for reasons I've just said, I just don't think it's
20 wise to put yourself in that position.

21 Q. Is there anything in the contract that you
22 have with him that says he's not supposed to drive?

23 A. Not to my knowledge.

24 Q. Okay. But it's -- if he's taking a
25 narcotic and he drives that is dangerous?

1 A. It could be dangerous. As I said, it's not
2 dangerous for everybody. But I would not take that
3 risk. If I was on those medications I would not do
4 that I hope.

5 Q. And it is your opinion that he cannot or
6 should not drive?

7 A. It is my opinion that he should not drive
8 because if he's in an accident he'll be blamed
9 whether it's his fault or not.

10 Q. It's like driving drunk?

11 A. Like driving drunk, yes. He's got a mind
12 altering substance in his blood.

13 Q. The contract you said is sometimes written
14 or sometimes verbal. Is the one with him written or
15 verbal?

16 A. I can't find a written drug contract in his
17 EMR, so I have to assume it's verbal. I don't know.

18 Q. He comes to see you basically on a monthly
19 basis to get his morphine, is that correct?

20 A. Correct.

21 Q. And he told you that he needs the morphine
22 because it helps him calm down?

23 A. Well, it's my understanding he needs it for
24 his headaches and his neck pain.

25 Q. If you look at your office note from April

1 22, 2016?

2 A. Yes, I'm at that note.

3 Q. If you would look at the fifth paragraph I
4 believe, it says, he needs to be on the medication
5 which helps him calm down.

6 A. That's probably referring to the
7 Citalopram, Lexapro that he's on. That's an
8 antidepressant.

9 Q. What he's coming back for though, the plan
10 at the bottom is to renew his morphine?

11 A. Uh-huh.

12 Q. Correct?

13 A. Yes.

14 Q. And the reference to the medication, that's
15 not to the morphine?

16 A. No, that's the problem with reading these
17 records after the fact or for litigation, things
18 like this, no, it's nothing at all about that. I
19 think it refers to he's -- we're treating like six
20 different things here. At this trial we're only
21 focused on the head injury and the narcotics. But
22 as a result of the injury he got depressed. And he
23 was placed on an antidepressant Citalopram, Lexapro,
24 and that helps him focus, that helps him calm down.

25 Q. If you would look at the office note from

1 April 22, under the portion that says subjective,
2 which is where you're talking with him and where we
3 see the note about medication helps him calm down,
4 is there any reference at all, and it's a full page
5 of notes, is there any reference at all in that full
6 page of notes about Lexapro?

7 A. Yes. Under the medication list if you look
8 down at the bottom of that note, one of his
9 medications is Lexapro, Citalopram, 20 milligrams
10 daily. And I know that that medication is used to
11 help people who are stressed, who are anxious.

12 Q. And you're looking at --

13 MR. HELMS: Hold on, hold on. Let him
14 finish his answer.

15 A. And that is one of the reasons why I
16 prescribe that medication. So I would not --
17 personally, I generally do not prescribe narcotics
18 to help people calm down. So when I'm reading this
19 note months later I know that I would have put a
20 sentence in there, he needs to be on the medication,
21 it helps him calm down, it refers more to the
22 Lexapro than it does to the narcotic.

23 Q. Again, I'm going to ask you, the report
24 from that day is actually a three page report. The
25 first page is under the heading, subjective. Then

1 there's a second page that has, objective,
2 assessment, and plan. And then there's a third page
3 that has medications on it.

4 A. Okay. It's all on one page here in the
5 EMR.

6 Q. Under the heading subjective it's a full
7 page of notes that you've taken for your meeting
8 with him. And subjective is basically a discussion
9 that you have with him, correct?

10 A. Correct.

11 Q. And under the heading subjective is there
12 any reference there to Lexapro? I'll tell you what
13 we could do, Doctor, to shorten this.

14 A. Yes.

15 MR. PICKETT: Let's go off the record
16 for a second.

17 THE VIDEOGRAPHER: The time is 10:44.
18 We are going off the video record.

19 (Discussion held off the record.)

20 THE VIDEOGRAPHER: The time is 10:46.
21 We are back on the video record.

22 Q. Dr. Eckel, I am going to hand you what's
23 been marked as Defendant Exhibit 1, which is a
24 collective exhibit of printouts of your office notes
25 from your visits with Mr. Newcomb from April 2016

1 through December of 2016. Is that correct?

2 A. Correct.

3 Q. Can you review those to make sure that is
4 what those are?

5 A. Okay.

6 Q. And these are the hard copies of what
7 you've been referring to in electronic fashion --

8 A. That's correct.

9 Q. And these are recordings of your office
10 notes as you have met with Mr. Newcomb during those
11 months of April through December 2016?

12 A. Yes.

13 Q. And under the subjective part of those
14 reports that is the intake or the conversation that
15 you had with Mr. Newcomb that you've recorded on
16 each of those dates?

17 A. Right.

18 Q. And then we've also talked about other
19 sections of each day for the medications, for the
20 plan, for that sort of thing?

21 A. Yes.

22 Q. But those are true and correct copies of
23 your records?

24 A. The subjective area is the historical part
25 of the medical record you take history from the

1 patient.

2 Q. That's the conversation you have with him
3 each day?

4 A. Correct.

5 Q. Those are true and correct copies of your
6 records?

7 A. As far as I can tell, yes.

8 Q. Are you still providing long term pain
9 medication management to Mr. Newcomb?

10 A. Yes, I am.

11 Q. And one of the medications that you're
12 managing for him is morphine?

13 A. Yes.

14 Q. Just like you were doing pain medication
15 for him back in March of 2013 before this accident
16 and for years before that?

17 A. Yes, a little bit different now because the
18 pain is worse and more intense. Before he did not
19 need the medication every day. It was more flare
20 ups.

21 Q. And these are more powerful narcotics he's
22 taking?

23 A. More powerful.

24 Q. He has graduated from Vicodin to Percocet
25 to OxyContin to Oxycodone and now to morphine?

1 MR. HELMS: Object to the form.

2 A. No. Actually Oxycodone, Hydrocodone
3 basically are the same. That's kind of a mild
4 narcotic, that's about as mild as you could get for
5 episodic pain. Then he had this accident and now
6 he's got constant pain. The Oxycodone is a long
7 form -- the OxyContin was a long form of the
8 Oxycodone, just extended release, so you take less
9 tablets. And the morphine extended release is
10 similar, and the reason for the change is he lost
11 his coverage for the OxyContin, couldn't afford it
12 to pay cash, so this is a cheaper medication.

13 Q. And, again --

14 A. And actually that's the only reason for the
15 change because I prefer the other medication because
16 it's abuse proof.

17 Q. And morphine is not abuse proof?

18 A. OxyContin has some features to it that
19 prevent it from being abused.

20 Q. The injury that you saw him for shortly
21 after -- or on June I guess the 24th of 2013, that
22 injury was to the left side of his head?

23 A. Correct.

24 MR. PICKETT: That's all the questions
25 I have.

* * * *

REDIRECT EXAMINATION

* * * *

BY MR. HELMS:

Q. Doctor, do you want take a short break? I must ask some follow up questions.

A. That's fine.

Q. You ready?

A. Yes.

Q. You were asked about some dizziness back in 2004 that Mr. Newcomb suffered.

A. Yes.

Q. Was that permanent or was that short term?

A. That was just short term. I really thought at that time, reviewing my records, I really thought that was an emotional situation he was going through.

Q. Back in 2004?

A. Back in 2004.

Q. Did that episode of dizziness cause him to lose any time from work?

A. If I recall in reviewing the record that dizziness was 2002.

Q. Okay. I'm sorry.

A. And that was he had just lost his job or

1 had stopped driving or something and emotionally it
2 was a tough thing for him and he was going through a
3 hard time then.

4 Q. Have any long term effects on his ability
5 to work?

6 A. No, no, it was a temporary situation that
7 resolved.

8 Q. That dizziness he suffered back in 2002,
9 was that anything like the dizziness he suffers now?

10 A. No, completely different injury, completely
11 different problem.

12 Q. Is it more -- is it worse now than it was
13 in 2002?

14 MR. PICKETT: Objection, leading.

15 Q. Which was worse, 2002 or now?

16 A. Now. I mean, this was a different injury.
17 This is totally different really.

18 Q. 2004, you were asked several questions
19 about headaches he had in 2004 due to I think he hit
20 his forehead on something?

21 A. Correct.

22 Q. And I take it it was a car wreck, he hit
23 the steering wheel or hit the dashboard or
24 something?

25 A. Yeah. I believe he was -- it was with a

1 truck, 18 wheeler I thought I saw, a truck accident.
2 Back on November 1, 2004 he was in a truck accident
3 Thursday morning at 3 a.m.

4 Q. Did those headaches cause him long term
5 disability being out of work?

6 A. No. That's a good example. I mean, I said
7 head injury at that time. That was a minor thing.
8 Sometimes people do things like this, hit their head
9 off the dashboard or whatever with no sequelae, have
10 no brain --

11 Q. When you say sequelae?

12 A. No complications, no problems from it.
13 They have some initial soft tissue injury,
14 laceration, might even have some central nervous
15 system, brain problems, thinking, confusion, memory
16 problems, but they get better. And that usually
17 happens short term. That apparently was this kind
18 of situation. It was a minor concussion you could
19 say. Actually not loss of consciousness, but you
20 could still whack the brain and not lose
21 consciousness but have some minor abnormalities.

22 That's why we're finding these things
23 out in sports where you have some minor damage to
24 the brain, maybe or maybe not loss of consciousness,
25 but the brain is affected. That's why it's so

1 dangerous to put those kids back into play right
2 away because the brain isn't working right and they
3 can't recover. If they get hit again they can't
4 recover and a second injury is much, much more
5 dangerous.

6 So he recovered apparently from this
7 injury. But the injury that we're talking about now
8 from the accident of June --

9 Q. 2013.

10 A. 2013. That was much worse. And he hasn't
11 recovered and he won't recover.

12 Q. Did you give Mr. Newcomb his D.O.T.
13 physical so he could drive a truck?

14 A. Maybe initially. They've changed the law
15 in Pennsylvania that now there's a special
16 certification to do that I don't do them. I elected
17 not to do that.

18 Q. Based on your yearly visits you saw him
19 from 2002 to 2013. Did he ever have a condition
20 that you felt would disqualify him from driving a
21 long haul tractor trailer?

22 A. No. With the provision I told him not to
23 drive when he was on the narcotics for his neck
24 pain.

25 Q. Yeah, that was going to be my next question

1 too. The Percocet or the Vicodin he took for his
2 neck and I think his knee pain over the years, did
3 those, you were just prescribing those for his neck
4 and knee pain, did that disqualify him in any kind
5 of way in your opinion from driving a long haul
6 truck?

7 A. Only from the fact that he shouldn't take
8 it when he's driving because if he was in an
9 accident it would be a problem.

10 Q. Did he ever indicate to you that he was
11 taking those medications and driving a tractor
12 trailer?

13 A. No. I think -- because I would ask him
14 about it and he would give me the right answer and
15 say no.

16 Q. There was a mention back in 2009 I think he
17 suffered an injury to his right eye. I think it was
18 2009, some point right in there. Did that have any
19 long term affect on his ability to work?

20 A. What is this injury we're talking about?

21 Q. He asked you about an injury to his right
22 eye, it was in connection with a laceration to the
23 forehead.

24 A. Oh, that was back in 2004.

25 Q. 2004.

1 A. Yeah. Well that injury, that was a
2 question about ptosis, that means dropping of the
3 eyelid, he had swelling of the right eye. But yeah,
4 that was all temporary, he recovered from that.

5 Q. Did that in any way affect his ability to
6 work or drive a long haul drive for the next nine
7 years?

8 A. No, it did not affect his ability to drive.
9 In fact, he did drive after that.

10 Q. We've been through the issue about the
11 Percocet and the Vicodin and the morphine. There
12 was a series of questions he asked you about this
13 issue of calming down. Do you treat patients as a
14 family physician for depression and agitation, do
15 you see patients for that?

16 A. I see them every day. And as a matter of
17 fact, that's one of the things I like to treat in
18 family medicine, depression and anxiety.

19 Q. And do you prescribe medications that help
20 them with that?

21 A. I do.

22 Q. Were you prescribing medications to treat
23 Mr. Newcomb's depression and agitation?

24 A. I was.

25 Q. And what were those medications?

1 A. He was on Lexapro, 20 milligrams, which is
2 an antidepressant. It's a member of the SSRI class
3 which raises a chemical called serotonin. It raises
4 those levels in the brain. It works for depression
5 and works also for anxiety.

6 Q. Were those the medications that you were
7 giving him for -- to help him calm down as opposed
8 to morphine?

9 A. Yes. I would say that I would refer more
10 to that. You know, narcotics can help calm you down
11 too, but the Lexapro, that's why it was prescribed.

12 Q. You've treated a -- I'm sorry.

13 A. And I wouldn't -- somebody that was
14 agitated or depressed or anxious, I would never give
15 them narcotics to treat that. That's not a reason
16 to do that. That's like killing a fly with a
17 sledgehammer. You know, you would use something
18 much safer that's not addicting like Lexapro.

19 Q. You've treated people here in Danville,
20 coal country, who get injured and can't work, is
21 that right?

22 A. Yes, I have.

23 Q. Men?

24 A. Men and women.

25 Q. How does that affect them generally when

1 they're no longer able to work and labor and earn a
2 living?

3 A. Well, it's probably true the world over,
4 but around here, you know, like most men they --
5 their thing is working and they want to provide for
6 their family. And Michael is no exception, he wants
7 to get back to work.

8 Q. Does that lead to depression if they can't
9 get back to work?

10 A. Absolutely.

11 Q. In your opinion within a reasonable degree
12 of medical probability based on being a family
13 physician for all these years, has Mr. Newcomb's
14 inability to work and labor led to his depression?

15 MR. PICKETT: Objection, leading.

16 A. Well, I can state clearly to a reasonable
17 degree of medical certainty that this accident has
18 seriously and permanently altered Michael Newcomb's
19 life and he is not the man today that he was before
20 the accident. And I would say most of that, it's
21 not the physical stuff, it's the emotional fact that
22 he cannot work any longer and provide for his
23 family.

24 Q. As it relates to the depression?

25 A. As it relates to the depression and the

1 disability really, really the disability that he
2 can't work.

3 Q. There was several times the question was
4 emphasized about the injury to his -- was to the
5 left side of his head. Did you ever see any records
6 where Mr. Newcomb was complaining of increased pain
7 to the right side of his head?

8 A. I can't recall.

9 Q. Would you find that unusual?

10 A. No.

11 Q. Did he ever complain of, you know,
12 generalized -- I mean, specific pain as opposed to
13 general headaches?

14 A. No, I mean, he had a headache encompassing
15 the whole head. I mean, he wouldn't just limit it
16 to the area on his scalp on the left side, sometimes
17 it would just from the neck up hurt.

18 Q. Is there any question in your mind that
19 his, the headaches that he suffers now after June of
20 2013 were caused by this incident, as a medical
21 professional?

22 A. No. Certainly he had headaches before, and
23 in that sense this accident has made those worse.
24 But I think he has new headaches on top of it caused
25 by this accident.

1 Q. And, Doctor, would you ever prescribe
2 medication to Mr. Newcomb or any patient if you did
3 not in your professional opinion believe they were
4 absolutely medically necessary for his condition?

5 A. No, I would not.

6 MR. HELMS: Doctor, we appreciate it
7 very much.

8 THE WITNESS: Thank you.

9 MR. HELMS: And it's snowing outside.

10 MR. PICKETT: I don't have anything
11 else.

12 THE VIDEOGRAPHER: The time is 11:03.
13 That concludes this video deposition.

14 (The deposition concluded at 11:03 a.m.)
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_____, 2016

I hereby certify that
the evidence and proceedings are contained fully and
accurately in the notes taken by me of the testimony
of the within witness who was duly sworn by me, and
that this is a correct transcript of the same.

Justine Starrick
Registered Professional Reporter
Notary Public

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